Ensuring the Future Physician Workforce Act of 2008
S. 2729
Summary

Reset the Sustainable Growth Rate to 2007 Spending Target
This provision would provide a positive physician update for July 1, 2008 to December 31, 2008 and 2009.

Eliminate the Sustainable Growth Rate beginning in 2010 - Replace it with Medicare Economic Index (MEI)
This would repeal SUSTAINABLE GROWTH RATE in 2010 and produce stable, predictable updates by the use of the MEI.

Increased bonus payments beginning in 2009; New bonus payment for reporting on the top 10 most expensive disorders covered by Medicare to begin in 2010
Reporting measures play a role in improving quality medical treatment. Because Medicare treats some of the country's sickest patients, it is important that Medicare constantly seek to improve the care it provides. Unfortunately the incentives to report such data are not adequate. Starting in 2009, the bonus payment would increase for quality reporting from 1.5 percent to 3 percent. In 2010, eligible measures would focus on the 10 highest cost disease conditions. By examining the most expensive disorders, we can focus our efforts to improve efficiency and find savings within the system.

3% bonus payments beginning in 2008 for HIT implementation
HIT facilitates access to information and increased coordination of care between providers, minimizing mistakes, and simplifying the billing and reporting processes. However, the initial cost of hardware/software and training is often a deterrent. This legislation provides 3 years of bonus payments to offset the start-up costs of adopting HIT.

Safe-harbor from anti-kickback laws when implementing HIT
Doctors in private practice contract to be able to admit patients to local hospitals. Hospitals are usually more likely than small practices to have adopted some form of HIT, and it is helpful for the physician and the hospital to have interactive computer systems. However, current anti-kickback law makes it illegal for doctors to accept hardware/software from hospitals under any circumstances. We suggest that the hospital should be allowed to help with HIT implementation, as long as they do not restrict the physician's HIT interoperability, clinical practice, or referral system for their own financial benefit.

Confidential reports for physicians on Medicare billing
Physicians often do not know the extent of their billing to Medicare. Each physician would receive a confidential, informative report on their billing practices, compared to those of other area physicians, so that physicians can personally examine their practice behavior. The Secretary is explicitly prevented from using these reports to determine or alter physician reimbursements.

Reports to Medicare beneficiaries on utilization
Like physicians, Medicare beneficiaries are often unaware of the cost of their care. Each beneficiary would receive a confidential annual report on the amount of payments made to or on the behalf of the individual (Parts A and B). By empowering patients, they can compare their services and choose to discuss this information with their physicians.

Medicare spending studies to be conducted as a result of the legislation:
- **Collect data on Medicare savings gained by diverting hospital stays with out-patient care**
- **Create an on-going examination of Medicare funding**
- **Study the RUC process**
  Despite the fact that medicine changes rapidly, some services remain overvalued and therefore inequitably reward those who provide these services and punish those who do not. An independent entity would study the process.
- **Study healthcare disparities**

We propose examining the impact of reporting requirements on physician penetration in high-risk health condition areas and minority communities.